Voluntary Workers Claim Form

THIS IS THE FORM TO USE WHEN MAKING A CLAIM ON ANY VOLUNTARY WORKERS POLICY PROVIDED BY AFA PTY LTD ABN 83 067 084 333, AFSL 247122 ON BEHALF OF ZURICH AUSTRALIAN INSURANCE LIMITED ABN 13 000 296 640 AFSL 232507.

Instructions to assist with the completion of this form

Correct completion of these forms will assist us to make accurate and faster decisions regarding our customers' claim for benefits and ensure that where benefits are payable that they reach our customers in a timely manner. Incomplete claim forms will be returned for completion, leading to assessment delays.

IMPORTANT NOTE

There are **four** sections to this claim form

Sections one, two, three and four must be completed in all cases.

Section one: **CLAIMANT CERTIFICATION** is to be completed by the person making the claim (the injured person)

Section two: **MEDICAL CERTIFICATION** is to be completed by the registered medical practitioner who is/or has been involved in treating the person making the claim (ANY FEE INCURRED FOR COMPLETION OF THIS FORM BY THE DOCTOR IS THE RESPONSIBILITY OF THE PERSON MAKING THE CLAIM)

Section three: **FINANCIAL CERTIFICATION** is to be completed by the person making the claim or their employer (see instructions in that section)

Section four: **ASSOCIATION DECLARATION** is to be completed by the organisation for whom the person making the claim was performing voluntary work at the time they were injured

ELECTRONIC FUNDS TRANSFER FORM (EFT) for Claim Payments

Important: Should your claim be accepted & benefits are payable we will require your acount details. Please be sure to complete the following section so that payments can be processed.

Claimant's name:

Name of Bank/Credit Union:

BSB Number (6-digit number)

Account name:

Account Number

I authorise AFA Pty Ltd to directly credit claim benefits to my account as noted above.

Signature of Claimant authorising EFT benefits:

Date / /

Note: Providing your account details above does not mean that your claim is acceptable and quality you for benefits.

This form is used to initiate a claim only

SECTION 1 Claimant certification

To be completed by the person making the claim (the injured or sick person)

Policy No

1.1 Your details

First name

Surname

Date of birth

/ /

Gender

Male Female Non-Binary

Full address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Address for correspondence (if different) Number and street

Suburb/town

State

Postcode

Contact number during business hours

( )

After hours number

( )

Mobile number

Email address

Do you consent to receive important information about your claim via email?

No Yes

1.2 Details of your occupation

What is your occupation?

How many years have you been in this occupation?

years

How many hours do you work per week?

hours

When did you join your current employer or start operating your business?

/ /

List here all the duties of your occupation and the average time (percentage) you perform each duty per week

Percentage of time doing, and type of, sedentary/light duties	Percentage of time doing, and type of, manual duties

How long have you been performing the duties listed above? years

In what occupations have you worked?

from

to (years)

Which of the following are you? (please tick)

a) An employee ... By whom are you employed/or for whom do you work? (business or company name)

Employer's address

State

Postcode

b) Self employed ... What is your business structure? (eg. Sole trader/ partnership/company)

Do you have any employees?

No Yes If so, how many

If you are/have been unable to work in your business because of sickness or injury, have your employees continued to work in your absence?

No Yes

What percentage of business expenses if any is your partner (or other person) responsible for? %

c) A contractor

d) A subcontractor

e) Other ... Please provide details here

1.3 Details of the injury claimed Complete this section only if you are claiming for an injury caused by an accident.

If you are claiming for a sickness then you need to complete Section 1.4 on page 4.

1. If you were injured, what is the **injury**?

2. If you were injured, please describe fully how the **injury** occurred

3. If you were injured, what is the street address where you were **injured**? Suburb/town State Postcode

4. If you were injured, were you working, or at work, at the time of the **injury**?

5. If you were injured, were you travelling to, or from, work at the time of the **injury**? No Yes

6. If you were injured, what were you actually doing at the time you were **injured**?

7. When did you **first** see a doctor for the injury and who was the doctor you first saw?
   on / /

8. If you were injured please tell us the time it happened AM/PM on / /

9. Nominate the names and addresses of two witnesses who saw you injure yourself

   Witness 1: Name
   Address
   Suburb/town State Postcode
   Contact number
   ( )

   Witness 2: Name
   Address
   Suburb/town State Postcode
   Contact number
   ( )

10. Did you cease all duties as a result of this injury?
    No Yes On what date? / /

11. Is this **the first time you have EVER injured** this part of your body?
    Yes No If yes, please skip to question 14

12. If you have **EVER previously injured this part of your body** please advise the date it happened, the nature of the injury and how it occurred

13. Which doctor, hospital or medical centre, if any, did you consult **the previous time** you injured yourself?
    I previously saw Doctor (their name) for injury to this part of my body on (the date) / /

14. Are you entitled to, and/or have you now made, or intend to make, a claim for benefits of any type in regard to injury to this part of your body? (eg, worker's compensation, public liability, compulsory third party motor vehicle insurance, Centrelink, other insurer, etc)
    No Yes If so, provide full details ... Claim made on / /
    Claim made against (organisation) Policy number
    Indicate the outcome of the claim here (eg, accepted, paid, declined, amount paid etc)

15. Are you in receipt of any wages, salary, paid sick leave or income from any other source?
    No Yes If so, please provide details

16. Have you returned to work **in any capacity** yet?
    No Yes full time capacity part time capacity
    If so, please state the date on which you first returned here / /

17. If you have NOT yet returned to work, when do YOU expect that you will be able to do so?
    / /

1.4 Your medical treatment

1. Were you admitted to hospital?
   No ☐ Yes ☐ If admitted, which hospital were you admitted to? (please attach a copy of the hospital admission or discharge summary)

2. On what date were you admitted to hospital? ☐☐ / ☐☐ / ☐☐☐☐
   On what date were you released? ☐☐ / ☐☐ / ☐☐☐☐

3. Is the doctor that you have been seeing for your injury or sickness your usual treating doctor?
   Yes ☐ No ☐ If not, how long have you been seeing this current doctor? ☐☐ days ☐☐ months ☐☐ years

4. Who is your usual treating doctor and what is the address of their practice?
   Doctor's name
   Telephone number (☐☐)
   Full address of practice
   Suburb/town
   Postcode
   State
   Contact number (☐☐)

5. Have you been referred to a specialist?
   No ☐ Yes ☐ Please provide the names and addresses of specialists you have been referred to.
   Specialist: Name
   Address
   Suburb/town
   Postcode
   State
   Contact number (☐☐)

6. If you have been referred to a specialist are you still consulting the specialist?
   No ☐ Yes ☐

7. What tests have you undergone (for example CT scan, MEI, blood) and when? Please attach copies.

Date	Tests

8. What medical treatment, including medication and therapies are you currently receiving and how frequently?

1.5 Non Medicare Medical Expenses

IMPORTANT: PLEASE DO NOT ATTACH ACCOUNTS PAID OR PART PAID BY MEDICARE

The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount)

1. Are you a member of an Ambulance Service?
   No ☐ Yes ☐ If Yes, please give details

2. Are you a member of a Private Health Fund?

No ☐ Yes ☐ If Yes, please give details

3. Does your Private Health Insurance have hospital cover?

No ☐ Yes ☐

4. Does your Private Health Insurance cover extras (Physio etc)?

No ☐ Yes ☐

Please attach copies of the receipts and private health rebates (if applicable).

Name of provider	Service (e.g. Physio)	Date of Service	Charged amount	Private Health Rebate	Amount Claimable
				Total (AUD)	
				Less excess (AUD)	
				Total amount of claim (AUD)	

1.6 Declaration and Information Authorities

I understand that AFA Pty Ltd (ABN 83 067 084 333, AFS License No. 247122) may need to access, collect and disclose information about me in order to be able to assess my claim for benefits.

In order to do so, I (insert your full name here)

of (your address)

Suburb/town | Postcode | State

hereby agree that I have read, understood and agree to the collection, use and disclosure of my personal information by AFA Pty Ltd as outlined in the Privacy Notice on page 12 of this document.

In addition and without limiting the above, I authorise AFA Pty Ltd to collect and disclose any information about me from and to any organisation or person including the following, (which includes their current and former capacities and any organisation or person that may replace them): Medicare, any insurance or health insurance company, other insurance intermediaries, Centrelink, any hospital, physician, medical practice, medical services provider, medical therapy provider, employer, investigators, assessors and loss adjustors, other parties we may be able to claim or recover against, insurance reference bureau, financial institutions including banks, the Australian Taxation Office and my accountant.

In providing or obtaining information about me, I understand that AFA Pty Ltd will use that information in the assessment of my claim, and that if I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd, notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any misrepresentations, false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that subject to law, the policy may be cancelled and/or AFA Pty Ltd may refuse to pay a claim.

Signature

Date

/ /

To be completed if another person has signed on behalf of the person claiming

Name of person who signed on behalf of the person claiming

Relationship to the person claiming

Reason why the person claiming could not sign

SECTION 2 Medical certification

This part of the claim form must be completed by a registered doctor who is certifying that the injured person is, or was injured and/or disabled from working.

Please note that any fee incurred for the completion of this medical certification form is the responsibility of the patient.

Please note that medical certification is not accepted prior to the date you have first been consulted for this medical condition.

2.1 Patient's details

First name

Surname

Date of birth / /

Male Female

Full address (Note: we do not accept post office boxes as the address) Number and street

Suburb/town

State

Postcode

1. How long has the patient been known at your practice? years
2. Are you the patient's primary treating physician at your practice?
   Yes No If not, please provide details of the physician who is
3. What do you understand the duties of the patient's occupation/business to be?
4. What percentage of the patient's duties are sedentary?
5. What is the clinical medical diagnosis for which the patient is claiming to be disabled from working?
6. What are the reported symptoms?
7. When did these symptoms first manifest?
   / /
8. What are the current symptoms?
9. When did the patient first consult you in regard to this period of disability?
   / /
10. When was the diagnosis reached?
    / /
11. Was there any previous history of this or of a similar condition?
    No Yes If so, please provide full details of the dates and the nature of the previous history of the injury or sickness
12. If the patient sustained an injury, what were the circumstances of the injury?
13. If this condition is not related to an injury, what is the cause of the patient's disability?
14. On what date did the injury/accident occur?
    / /

2.2 Specifics of disability

1. On page 2 section 1.2 of this claim form, the patient has provided a breakdown of their occupational duties and the percentage of time spent engaged in each duty per week.

   In consideration of these duties and hours, please provide the following information.

   1.1 Has the patient been **ENTIRELY PREVENTED** from engaging in their occupation by the medical condition?

   No ☐ Yes ☐ If so, from what date ☐☐ / ☐☐ / ☐☐☐☐

   to what date ☐☐ / ☐☐ / ☐☐☐☐

   1.2. Has the patient **ONLY BEEN PARTIALLY PREVENTED** from engaging in their occupation by the medical condition?

   No ☐ Yes ☐ If so, from what date ☐☐ / ☐☐ / ☐☐☐☐

   to what date ☐☐ / ☐☐ / ☐☐☐☐

   1.3. Is the patient now capable of a return to **FULL TIME** duties?

   No ☐ Yes ☐ If so, from what date ☐☐ / ☐☐ / ☐☐☐☐

   1.4. Is the patient now capable of a return to **PARTIAL DUTIES**?

   No ☐ Yes ☐ If so, from what date ☐☐ / ☐☐ / ☐☐☐☐

2. If the patient is not yet capable of returning to **FULL TIME DUTIES**, what is currently preventing them from doing so?

3. If the patient is not yet capable of returning to **PARTIAL DUTIES**, what is currently preventing them from doing so?

4. What duties of their occupation could the patient currently perform and for how many hours per week?

   Duty

   for hours per week ☐☐

5. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis. (Please attach copies.)

Date	Tests

   Conducted by

   Result

6. Has the patient been referred to a specialist?

   No ☐ Yes ☐ Please provide name and contact details of the specialist

7. What is the current regime of medical treatment?(medication, therapies, surgery etc)

8. Are there any concurrent conditions, which are affecting the patient's ability to return to work? (eg, depression/anxiety)

   No ☐ Yes ☐ Please state what the concurrent condition is and to what degree it prevents/restricts the patient returning to their occupation

9. Are there any other non-medical factors (eg work imposed barriers) affecting the patient's ability to work?

   No ☐ Yes ☐ Please provide details

2.2 Specifics of disability continued

10. Are you providing information in respect of this patient to any other insurer?

No ☐ Yes ☐ If so, which insurer?

11. Did you examine this patient before completing this form?

No ☐ Yes ☐ Please provide details

Doctor's declaration

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signature

Date

/ /

Name

Qualifications

Practice address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Telephone number

( )

SECTION 3 Financial certification

Important instructions

1. If you are **SELF EMPLOYED** you must complete the first section on this page. You MUST provide a copy of your entire Individual Taxation Return & Notice of Assessment for the financial year immediately prior to your ceasing work due to your Injury or Sickness and if you are a company/partnership please also provide a copy of your entire Business Taxation Return. If you operate a Trust as part of your business structure you must also include a full copy of the entire Trust Taxation Return.
2. If you are an **EMPLOYEE, CONTRACTOR or SUB-CONTRACTOR**, your employer or principal contractor must complete the second section on page 11. Acceptable proof of income includes a copy of your entire Individual Taxation Return AND Notice of Assessment for the financial year immediately prior to your ceasing work due to your Injury or Sickness.
3. Claims which are not accompanied by the proof of income as requested above, **CANNOT BE ASSESSED**.

3.1 Self employed

If you are self employed, you must complete this section

Business/company name

ABN

Full address from which the business/company operates

Suburb/town

State

Postcode

What activity principally generated your income in the 12 months before you ceased work due to injury or sickness?

Have you changed your occupation in the 12 months before you ceased work due to injury or sickness?

No ☐ Yes ☐ If so, please tell us what your occupation has changed from

to

on / /

Was any of the income you earned in the 12 months before you ceased work due to injury or sickness split with a spouse or partner ?

No ☐ Yes ☐ If so, please provide the percentage %

Your Accountants' Name

Full address from which the business/company operates

Suburb/town

State

Postcode

Accountants' office telephone number

( )

Did you/your accountant complete and lodge a taxation return for the last two financial years? No ☐ Yes ☐

3.2 An employee

If you are an EMPLOYEE, CONTRACTOR OR SUBCONTRACTOR your employer or principal contractor must complete this section

I hereby certify that (name of sick or injured person)

has been engaged/employed by the company/business since the date of / / in the position of

3.2.1 Did the person **ENTIRELY CEASE WORK** in their employment position?
No ☐ Yes ☐ If so, from what date / / to what date / /

3.2.2 Did the person **ONLY PARTIALLY CEASE WORK** in their employment position?
No ☐ Yes ☐ If so, from what date / / to what date / /

3.2.3 Has the patient now returned to **FULL TIME** duties?
No ☐ Yes ☐ If so, from what date / /

3.2.4 Has the patient now returned to **PARTIAL DUTIES**?
No ☐ Yes ☐ If so, from what date / /

3.2.5 Are there light or partial duties available within the company/business in which the person can work?
No ☐ Yes ☐ If so, please state what duties are available and what hours the person could be alternatively engaged by the company/business

3.2.6 During the period of incapacity did the claimant receive any of the following: -
Paid sick leave ☐ from / / to / / in the amount of $ per week
Workers comp. ☐ from / / to / / in the amount of $ per week

Gross Weekly Earnings averaged over the 12 months prior to disablement $ per week

Signature

Date / /

Name

Role (eg Supervisor/paymaster/human resources manager/owner/manager)

Company/business name

Full address (Note: we do not accept post office boxes as the address) Number and street

Suburb/town State Postcode

Telephone Number ( )

Fax Number ( )

Please attach pay advices for the 12 months prior to the employee's disability

SECTION 4 Organisational Declaration

Organisation Name

Organisation Official's Name

Organisation Offical Position

Address

Suburb | State | Postcode

Daytime contact number | Email (important)

I, the above mentioned Organisation Official, confirm that

(MEMBER'S NAME)

is a Voluntary Worker for the Organisation and was an insured person as identified in the Personal Accident Insurance with AFA Pty Ltd at the time of the accident. The information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Please include a copy of the incident report if applicable.

Are there any comments in relation to this claim? No ☐ Yes ☐ If Yes, please give details

Once the claim form has been completed, signed and dated please send it, along WITH ATTACHMENTS, to:-

AFA CLAIMS DEPARTMENT
PO Box 3763
Australia Fair QLD 4215

OR TO

YOUR
INSURANCE
BROKER

or email it to: claims@afainsurance.com.au

If you have any questions, or if you need assistance with understanding or completing this form, you can contact us on (toll-free) 1300 760 377. Please ensure that you keep copies of all documentation sent to AFA.

PRIVACY NOTICE

At AFA Pty Ltd (AFA) (ABN 83 067 084 333) we are committed to protecting your privacy in accordance with the *Privacy Act 1998* (Cth) and the Australian Privacy Principles (APPs).

This privacy notice details how we collect, disclose and handle your personal information as defined in the Act.

Personal information is essentially information or an opinion about an identified individual or an individual who is reasonably identifiable, whether the information or opinion is true or not and whether recorded in a material form or not.

Why we collect your personal information

We collect your personal information (including sensitive information) so we can:

- identify you and conduct necessary checks;
- determine what service or products we can provide to you e.g offer our insurance products;
- issue, manage and administer services and products provided to you or others, including claims investigation, handling and settlement;
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.

What happens if you don't give us your personal information?

If you choose not to provide us with the information we have requested, we may not be able to provide you with our services or products or properly manage and administer services and products provided to you or others.

How we collect your personal information

Collection can take place through websites (from data you input directly or through cookies and other web analytic tools), email, by telephone or in writing. We collect it directly from you unless you have consented to collection from someone other than you, it is unreasonable or impracticable for us to do so or the law permits us to.

If you provide us with personal information about another person you must only do so with their consent and agree to make them aware of this privacy notice.

Who we disclose your personal information to

We share your personal information with third parties for the collection purposes noted above.

The third parties include: our related companies and our representatives who provide services for us, our agents or contractors, our insurers, other insurers and reinsurers, your agents, premium funders, other insurance intermediaries, underwriting agents, our legal, accounting and other professional advisers, data warehouses and consultants, providers of medical and non-medical assistance and services, translators, investigators, loss assessors and adjusters, credit agencies, credit card providers and other parties we may be able to claim or recover against, your employer (if a corporate policy), anyone either of us appoint to review and handle complaints or disputes, other companies in the event of a corporate sale, merger, re-organisation, dissolution or similar event and our alliance and other business partners and any other parties where permitted or required by law.

We may need to disclose information to persons located overseas. Who they are may change from time to time. You can contact us for details or refer to our Privacy Policy available at our website afainsurance.com.au.

In some cases we may not be able to take reasonable steps to ensure they do not breach the Privacy Act and they may not be subject to the same level of protection or obligations that are offered by the Act. By proceeding to acquire our services and products you agree that you cannot seek redress under the Act or against us (to the extent permitted by law) and may not be able to seek redress overseas.

More information, access, correction or complaints

For more information about our Privacy practices including how we collect, use or disclose information, how to access or seek correction to your information or how to complain in relation to a breach of the Australian Privacy Principles and how such a complaint will be handled, please refer to our Privacy Policy. It is available at our website afainsurance.com.au or by contacting us or our Privacy Officer at AFA, PO Box 3763, Australia Fair QLD 4215 or by email to privacy@afainsurance.com.au, or by telephone on 1300 760 377.

Your Choices

You consent to this use and these disclosures unless you tell us otherwise. If you wish to withdraw your consent, including for things such as receiving information on products and offers by us or persons we have an association with, please contact us.

Contact us

By phone: 1300 760 377

By email: privacy@afainsurance.com.au

In writing: PO Box 3763, Australia Fair QLD 4215

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